



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR  
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: fsb@idhw.state.id.us

July 20, 2010

Tom Whittemore  
Communicare, Inc #7 Cougar  
40 West Franklin Road, Suite F  
Meridian, ID 83642

RE: Communicare, Inc #7 Cougar, provider #13G072

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #7 Cougar, which was conducted on July 15, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily

Tom Whittemore  
July 20, 2010  
Page 2 of 2

a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 1, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by August 1, 2010. If a request for informal dispute resolution is received after August 1, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/srp

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES


PRINTED: 07/16/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G072</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/15/2010</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #7 COUGAR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2903 &amp; 2907 COUGAR AVENUE NAMPA, ID 83686</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey.  The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Barbara Dern, QMRP  Common abbreviations/symbols used in this report are: AQMRP - Assistant Qualified Mental Retardation Professional QMRP - Qualified Mental Retardation Professional	W 000	<p style="text-align: center; font-size: 1.2em;">RECEIVED</p> <p style="text-align: center;">AUG 06 2010</p> <p style="text-align: center;">FACILITY STANDARDS</p>	09/15/2010
W 426	483.470(d)(3) CLIENT BATHROOMS  The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.  This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 4 of 4 individuals (Individuals #1, #2, #6, and #8) living on the men's side of the facility. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include:  1. The facility was split into 2 halves, with men living on one side of the facility and women living on the other. Hot water temperatures were obtained on the men's side of the facility during an environmental review on 7/14/10 from 9:15 - 9:45 a.m. and were recorded as follows:	W 426		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>8-5-2010</b>
---	-------------------------------	------------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G072</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #7 COUGAR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2903 &amp; 2907 COUGAR AVENUE NAMPA, ID 83686</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 426	Continued From page 1  Men's kitchen sink - 115.9 degrees. Men's hallway bathroom with shower - 115.6 degrees. Men's hallway powder room - 115.5 degrees.  When asked if the individuals residing on the men's side of the facility ( Individuals #1, #2, #6, and #8) could regulate water temperatures, the QMRP and AQMRP, who were both present, stated none of the individuals residing at the facility were able to self regulate water temperatures. At that time, the QMRP and AQMRP were notified of the water temperatures being too high.  The facility failed to ensure water temperatures were maintained at or below 110 degrees Fahrenheit.  Note: Water temperatures were re-checked on 7/15/10 at 5:12 a.m. and found to be below 110 degrees Fahrenheit.	W 426	are four consecutive checks within acceptable temperature ranges. The process will then revert to monthly checks with more regular checks again implemented if the temperature is too high.  Identifying Others Potentially Affected: All individuals living at this location are potentially affected.  System Changes: Please refer to Corrective Actions.  Monitoring: The AQMRP will send a copy of the "Annual Hot Water Temperature Check Log" with the Monthly Preventative Maintenance Check List.		
W 444	483.470(i)(1)(iii) EVACUATION DRILLS  The facility must hold evacuation drills to evaluate the effectiveness of emergency and disaster plans and procedures.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to properly evaluate the effectiveness of emergency and disaster plans and procedures for 8 of 8 (Individuals #1-#8) residing in the facility. This resulted in evacuation drills being run with higher numbers of staff than what was usually present on the night shift. The findings include:	W 444	<u>W444</u>  Corrective Actions: We have decided to develop an "Evacuation Drill Protocol" to supplement the Evacuation Drill Reporting form we currently use. Evacuation drills will be scheduled when the fewest number of staff are on duty per shift. The draft outline of this form is attached and we will complete this protocol for this location and subsequently train staff on its contents. Also attached are the QMRP checklist we use for monitoring and our Evacuation Drill problem solving format.	09/15/2010	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G072</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #7 COUGAR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2903 &amp; 2907 COUGAR AVENUE NAMPA, ID 83686</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 444	<p>Continued From page 2</p> <p>1. The facility's as-worked schedules for 7/09, 10/09, and 3/10 through 6/10 were reviewed. The schedules documented multiple night shifts with only one staff on duty. However, the quarterly evacuation drills were reviewed from 7/19/09 - 6/25/10. All evacuation drills documented the presence of two staff being involved in evacuations with the following evacuation times:</p> <ul style="list-style-type: none"> <li>- 6/25/10 at 1:15 a.m.: 4 minutes.</li> <li>- 3/19/10 at 12:05 a.m.: 5 minutes.</li> <li>- 10/23/09 at 5:30 a.m.: 5 minutes.</li> <li>- 7/17/09 at 6:00 a.m.: 5 minutes.</li> </ul> <p>When asked on 7/14/10 at 9:48 am, the QMRP stated evacuation drills were not conducted with only one staff present and he was not sure how long it would take to evacuate all individuals.</p> <p>Additionally, an evacuation drill utilizing one staff was conducted on 7/15/10 at 5:30 a.m. and documented an evacuation time of 13 minutes and 36 seconds.</p> <p>The facility failed to evaluate evacuation drills under actual working conditions with only one staff on duty.</p>	W 444	<p>Identifying Others Potentially Affected: All individuals living at this location are potentially affected.</p> <p>System Changes: Please refer to Corrective Actions.</p> <p>Monitoring: The QMRP will look at monthly evacuation drill reports as part of routine operations monitoring as verified on our QMRP Checklist system. Problematic evacuation drills will be processed by the management team with a copy of the plan sent to the Administrator.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G072</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #7 COUGAR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2903 &amp; 2907 COUGAR AVENUE NAMPA, ID 83686</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
M 000	<p>16.03.11 Initial Comments</p> <p>Communicare Inc.- Cougar, is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation.</p> <p>The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Barbara Dern, QMRP</p>	M 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG 06 2010</p> <p style="text-align: center;">FACILITY STANDARDS</p>		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

5699

N3SD11

If continuation sheet 1 of 1



### Annual Hot Water Temperature Check Log

#### CCI #7: Women's Side

### CCI #7: Women's Side

[illegible]



## QMRP MONTHLY CHECKLIST

QMRP: \_\_\_\_\_ Home # \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

1. WHEN MAKING/RECEIVING CONTACT RE: AN INDIVIDUAL

- ✓ Update QMRP Activity Log

2. WHEN AT ASSIGNED CCI LOCATION(S)

- ✓ Review Accident/Injury (A/I) Reports and Behavior Incident Reports (BIRs) since previous visit, initial, and comment as needed.
- ✓ Review and Initial Logs (Medical Observation, Observation and Contact, Outings, and Ancillary) since previous visit.
- ✓ Update Fall Analysis: review all falls since your previous visit. Document and include actions taken to prevent further occurrences on "Fall Analysis" form.
- ✓ Update QMRP Activity Log if not current.
- ✓ Family/Guardian Contact/Notification: check to make sure notification is documented for any relevant A/I or BIRs.

3. MONTHLY (check when you have completed this assignment)

- \_\_\_\_\_ Attend at least one of each assigned location's monthly staff meetings.
- \_\_\_\_\_ Attend Trending/Tracking Meeting; make sure previous assignments are completed prior to meeting; prepare for/attend psychiatric reviews either in conjunction with TT meetings or separately if necessary
- \_\_\_\_\_ Conduct Monthly Summaries/Data Based Program Reviews
- \_\_\_\_\_ Review/Investigate Problematic Evacuation Drills
- \_\_\_\_\_ Review Active Treatment Observations
- \_\_\_\_\_ Reviewed/Processed Medication Incident Reports
- \_\_\_\_\_ Review AQMRP and ILW Checklists for assigned locations

4. AS NEEDED (record individual(s) initials, if none, record NA)

- \_\_\_\_\_ Conducted IDT Meetings for \_\_\_\_\_
- \_\_\_\_\_ Prepared/Modified Informed Consents for \_\_\_\_\_
- \_\_\_\_\_ Prepared Discharge/Transfer Summary for \_\_\_\_\_
- \_\_\_\_\_ Processed New Admissions for \_\_\_\_\_
- \_\_\_\_\_ Updated/Developed BMPs for \_\_\_\_\_
- \_\_\_\_\_ Update/Oversee Development of Fall Prevention Plans \_\_\_\_\_
- \_\_\_\_\_ Updated/Developed Evacuation Drill Plans for \_\_\_\_\_
- \_\_\_\_\_ Participate in Update process to assist with problem solving

5. SEMI-ANNUAL/ANNUAL (check if completed this month)

- \_\_\_\_\_ Processed Annual IPPs and Informed Consents
- \_\_\_\_\_ Conduct one or more paperwork system observations: refer to "Observation & Feedback" module.
- \_\_\_\_\_ Conduct quality assurance review as determined by QMRP management team.

6. STAFF TRAINING (check if completed this month)

- \_\_\_\_\_ 1 One-Day Recertification
- \_\_\_\_\_ 2 One-Day Recertification
- \_\_\_\_\_ 1 Two-Day Certification

**CCI EVACUATION DRILL PROTOCOL**  
**CCI #7 (2809 Cougar Avenue, Nampa, ID 83651)**

-----DRAFT FORMAT-----

**EVACUATION DRILL SCHEDULE**

Evacuation drills are scheduled on CCI's Annual Calendars. Each quarter there is one drill scheduled per each shift and times rotate throughout the year. Drills are to occur when the fewest number of scheduled staff are on duty.

**PREPARATIONS PRIOR TO THE EVACUATION DRILL**

**DESIGNATED ASSEMBLY AREA**

**ASSIGNMENT OF STAFF**

Only staff scheduled to be on duty during specified time frames are to implement evacuation procedures. Management staff may be there to observe but are not to assist.

**If One Staff Is On Duty**

- Assist \_\_\_\_ to the assembly area
- Assist \_\_\_\_

**If Two Staff Are On Duty**

- Assist \_\_\_\_ to the assembly area
- Assist \_\_\_\_

**If Three Staff Are On Duty**

- Assist \_\_\_\_ to the assembly area
- Assist \_\_\_\_

**If Four Staff Are On Duty**

- Assist \_\_\_\_ to the assembly area
- Assist \_\_\_\_

**COMPLETION OF EVACUATION DRILL REPORT**

If a management staff member observes the evacuation drill, that person completes and signs the evacuation drill report. If an observer is not present, the report is to be completed by the most experienced staff on duty after the drill is finished.

**REVIEW OF EVACUATION DRILL REPORT**

**CommuniCare, Inc.**  
**Investigation Report Procedures/Problematic Evacuation Drills**

**INSTRUCTIONS:** This report is to be submitted to the Administrator within two weeks after an evacuation drill is determined to be problematic by the QMRP of the location where the drill occurred. Examples of problematic evacuation drills are drills exceeding ten (10) minutes and individuals refusing to leave during a drill.

The safety and protection of persons living at CommuniCare, Inc. is paramount. Investigations of problematic fire drills are necessary as a part of this process.

The typical investigative procedure is as follows:

1. The evacuation drill report is reviewed by the immediate supervisor of the location.
2. The immediate supervisor reports any problems to the QMRP.
3. The QMRP convenes a meeting of management staff to review the report, to identify issues and to discuss solutions.
4. The QMRP prepares a report and submits it to the Administrator for review/comment/authorization of actions to be taken.
5. Procedural corrections/modifications are implemented prior to the next evacuation drill.
6. After the next evacuation drill the evacuation drill report is reviewed and corrective actions assessed.
7. Step 1 is repeated each month.
8. Steps 2-6 are implemented based on the results of step #1.
9. The Administrator keeps a copy of the investigation and returns the original to the location's QMRP for filing.

Revised 08/10

**CommuniCare, Inc.**  
**Investigation Report/Evacuation Drills**

**Location (circle):** 1   2   3   4   5   6   7   CDS   8   9                      **Other (specify)** \_\_\_\_\_

**1.      Attach the problematic evacuation drill report.**

**2.      Name(s)/Location(s) of staff on-duty when the evacuation drill started:**


**3.      Summarize the problem(s) identified during the evacuation drill including what, when, where, and how the problem(s) occurred.**

**4.      What is the conclusion as to why did the problem(s) occurred?**

**5.      What are recommendations for corrective action?**

**Signature** \_\_\_\_\_ **Title** \_\_\_\_\_ **Date** \_\_\_\_\_

**16.      Administrative review and authorization for corrective action.**

**Signature** \_\_\_\_\_, **Administrator**                      **Date** \_\_\_\_\_